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Prison Group Counseling

Sabrina R. Haugebrook and Kristen M. Zgoba



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INTRODUCTION

The advent of group counseling, which helps offenders acclimate back into society, is not a new development. In the correctional setting, one component used by treatment staff is group counseling to adjust offenders to the outside community after institutionalization. How best to do that is of primary concern today, particularly with the influx of reentry initiatives throughout the corrections field in the late 1990s. The scope of correctional counseling is wide and with it comes a great deal of accountability.

Group counseling in prisons presents the counselor with many challenges, including protecting the safety and security of staff (custody and civilian) and dealing with the demands of the treatment needs of the offender population. Counseling in a prison setting is generally composed of education, treatment, casework (social work), and recreation (arts/ craft, sports). In this chapter, correctional group counseling is discussed and compared with numerous correctional facilities throughout the United States to see what types of services the offender population receives.

INSTITUTIONAL GROUP COUNSELING

Group counseling began during World War II; it was designed to rehabilitate military prisoners of the armed forces convicted of committing crimes. One of the earliest known structures

of group therapy for treating offenders termed the "guided group interaction," was practiced and developed by McCorkle and Wolf in the mid-1940s (as cited in Kratcoski, 2000, p. 483). In this form of counseling, military offenders at Fort Knox in Kentucky met in group sessions daily for treatment under the assumption that they could be restored to active duty once they completed the counseling groups (as cited in Lester & Braswell, 1987, p. 176).

McCorkle & Bixby (1951) developed a similar form of guided group interaction with juvenile offenders (as cited in Kratcoski, 2000, p. 483). In the Highfields Experiment in New Jersey, the criminologists (McCorkle, Elias, & Bixby, 1958) investigated their hypothesis that an established group treatment setting was ideal to treat youthful delinquents in training schools (as cited in Bennett, Rosenbaum, & McCullough, 1978, p. 41). The Highfields project, which was set up as a five-year experiment, began operating in 1950 with financial assistance from the New York Foundation and other donors. After the initial two-year joint venture between the State of New Jersey and the New York Foundation, the State of New Jersey's Department of Institutions and Agencies implemented the project into the New Jersey Correctional system (McCorkle et al., 1958, p. 12). The State of New Jersey assumed full control of the project on July 1, 1952. The aim of McCorkle and Bixby in creating Highfields was to change the attitudes and behavior of the juveniles to effect their rehabilitation, and the authors outlined four key features of the project design (Weeks, 1958, p. viii).

The features of the highfields experience are:

1. The informal and intimate living for a short period in a small group in a non-custodial residential center.
2. The experience of a regular routine of supervised work.
3. Evening GGI sessions designed to give the boys insight into the motivations for their conduct and incentive to change their attitudes.
4. To continue the group discussion during leisure time.

Boys in a certain age group were sent to Highfields as a diversion to avoid jail time. For admittance into Highfields, the average age was 16 years, with no prior correctional institutionalization or reform. When Highfields originated, the majority of the juvenile boys came from the most populated counties of the state. The counties of Bergen, Essex, Hudson, and Union sent boys to reroute them away from prison. The program could accommodate up to 20 boys in a four-month residency period. Usually a judge sentenced the boys to the program as a form of probation. The boys would arrive at the Highfields site in central New Jersey with their probation officer. There was no formal orientation, but the juveniles would receive further instructions once they arrived into the facility.

Guided group interaction began the same day the juveniles arrived at Highfields. The youth met five times a week (two separate groups) in the guided group interaction exercises and assumed responsibility for each other's actions. The facilitator (director of Highfields) stressed problem solving and often confrontation solving between the groups. The formal guided group interaction took place in the evenings, but the entire time the juveniles were in the program they participated in group interaction exercises. Anything could be brought up and discussed at the nightly group sessions. Emphasis was placed on creating situations in which the boys made choices about how to behave and then felt secure enough to discuss their choices with the group (McCorkle et al., 1958, p. 70).

The Highfields Experiment received broad attention as a innovative mechanism for counseling troubled juveniles. The program was evaluated after five years of operation. The evaluation conducted by Weeks (1958) compared Highfields with another New Jersey state-run facility, the Annandale Reformatory for Boys. Weeks concluded that the Highfields project worked because for every 100 boys sent to Highfields and Annandale, 63 Highfields residents completed their treatment and did not recidivate compared to 47 Annandale boys (Smith & Berlin, 1988, p. 396). Weeks (1958) sought to answer two other questions as well. He evaluated whether the juvenile boys changed their attitudes after treatment and whether short-term treatment changed the basic personality of the youthful offenders.

The highly favorable results of the Highfields Experiment spawned other programs throughout the State of New Jersey and the United States. Other state correctional systems replicated Highfields and guided group interaction for juvenile offenders. The Provo experiment on juvenile rehabilitation project in Utah, Essexfields group rehabilitation project in New Jersey and Southfields in Kentucky were three programs that adopted the Highfields model. In these projects, juvenile boys were sent to residential programs in the community instead of training schools. These experiments produced similar results in lowering recidivism through group peer counseling.

After World War II, the public was more sympathetic to the needs of offenders and desired reformation therapy that could correct the bad choices criminals made. Gone was the punitive era of locking a lawbreaker away from society. The practice of group counseling or guided group interaction spread and was adapted to fit the correctional institutional model. Group counseling at the time involved group activity generally led by a treating therapist or counselor. Group counseling placed a strong emphasis on many aspects of an offender's life such as job training and education. At the outset, most group counseling dealt with helping lawbreakers resolve or deal with the emotional troubles in their lives.

Group therapy continued to grow in the corrections field with other group rehabilitations, such as psychodrama (Moreno, 1957) and role-playing used by Slavson (1950). Both therapy sessions are somewhat similar, as all members of the group share and act out various parts of the community (family, peers, etc.) in the life of the offender. One aspect of the group counseling process was the therapeutic community (TC) model. The TC philosophy grew out of the works of Glasser (1965). He created a community based on reality therapy at the Ventura School for Girls in California (Bennett et al., 1978, p. 31). Glasser believed clients needed to be responsible for their actions, establish an identity, and learn to manage later actions with a realistic approach (as cited in Bennett et al., 1978, p. 31). He used the structure of the guided group interaction (GGI), in conjunction with other forms of group treatment in prison facilities. Glasser believed that anyone who seeks therapy suffers from an inability to realize his or her fundamental requirement in life.

Group counseling began in the correctional setting in the 1940s as a way to boost competence with prisoners. Group counseling may help with the inmate code. Offenders are open to counseling with others and the inmate code usually meant inmates mistrusted authority and other offenders. They include inmates trying to discuss their grievances with the prison administration by "conning" the treatment staff. Therefore, staff should be careful and recognize the characteristics of an offender who is trying to gain sympathy from treatment personnel.

Correctional counseling is progressing from a punitive focus to one in which inmates who are in counseling discover how to alter their behavior with support from the treatment staff, family, and fellow offenders. A counseling model that encompasses all levels of an offender's life is ideal because it may help deter the offender from returning to prison.

Therapeutic Community Counseling

In the therapeutic community, offenders who are imprisoned for a drug-related offense usually obtain treatment from specialized counselors with a background in substance abuse and addictions treatment. As designed, the therapeutic community makes inmates more amenable to treatment and less intimidating to staff. A treatment staff of professionals usually leads the group-counseling portion of the therapeutic community, but increasingly in many instances, inmates facilitate and direct many of the group sessions. In many prison sites, such as in the therapeutic community (TC), the offenders may lead some of the counseling sessions under the supervision of the treatment staff. In the TC setting, each participant is given the opportunity to correct deficiencies that hold them back. Correcting the deficient behavior in a familiar group setting with other compatible participants obliges individuals to be honest with themselves and other group members.

Some professionals in the field argue that the TC better prepares inmates for release than other treatment programs. Group counseling of a large number of offenders is economical because treatment is given to the entire group simultaneously. The public may be more accepting to the treatment of offenders in a prison, especially when outcome studies show that counseling may aid in reducing recidivism and repetitious criminal conduct.

After Martinson (1974) in his research in the early 1970s said that nothing works in corrections, the public started to turn against the level of correctional treatment for the inmate populace. Rehabilitation programs were seen as failures according to Martinson and his colleagues. Martinson and his colleagues evaluated correctional treatment programs from 1945 to 1967 (Martinson, 1974) and could not find one treatment program that reduced recidivism. Since Martinson and others assumed that treatment does not work, the public began to doubt anecdotal evidence that treatment programs rehabilitated offenders.

Mental Health Counseling in Prisons

According to the U.S. Bureau of Justice Statistics (BJS) report, *Provision of Mental Health Care in Prisons* (2001), 16 percent of the inmate population in U.S. prisons had or were known to have a mental related illness. Many inmates enter or leave the correctional system with mental health needs. Some offenders who enter prison have mental health needs that were never recognized or diagnosed until they became involved with the justice system. When an offender is branded as abnormal or unruly, treatment counseling along with medication management may provide the offender an outlet to manage their illness. The treatment of the mentally ill offender, while under the care of the criminal justice institution, is important to many stakeholders. Policy makers, mental health advocates, prison operations, treatment staff, the media and the community at large all have a vested interest in the treatment that mentally ill inmates receive.

The National Institute of Corrections (NIC) surveyed prison facilities in the United States in 1999 (*Provision of Mental Health Care in Prisons*, 2001). Initial identification of

mentally challenged ill inmates generally occurs with initial classification during the intake process. Under the current system, offenders are usually placed in treatment program with other offenders categorized as having a similar mental condition. However, many offenders are asymptomatic, displaying no warning signs or unusual behavior that could alarm prison custody staff. Some argue that placing severely mentally impaired offenders in segregation/isolation is not ideal for their treatment as it could make the offender more disruptive once the inmate returns to general population in the penitentiary (as cited in Kratcoski, 2000, p. 634). An ideal rehabilitation program (Coulson & Nutbrown, 1992) for mental offenders is more sensible.

In the assessment conducted by NIC under the guidance of BJS, most state departments of corrections mandate that custody staff who work around mentally challenged offenders receive preservice training. The number of service hours varies per institution in each state. Most states now have a cognitive-behavioral agenda in which mentally ill offenders receive some level of group counseling. Usually, this is completed because many offenders have co-occurring disorders (mental and substance abuse). One fundamental element in helping mentally ill offenders is the level of aftercare the inmates receive once they reenter the community (community can be general custody in the prison or the community the offender will return to once the sentence is served). The aftercare component is vital to helping offenders sustain their well-being.

CROSS-STATE COMPARISON

There are several correctional agencies around the United States with admirable models of counseling for the prisoner population. Although there are two systems working, criminal justice and treatment counseling, many state correctional departments have formed programs that show benefits to offenders in terms of solid treatment, which thereby could possibly reduce recidivism. The majority of counseling services for the inmate population throughout the country involve mental health, substance abuse, and sex offender group counseling. Texas, North Carolina, Ohio, and New Jersey correctional counseling and treatment systems are presented in this chapter.

Texas

In 1997 the Texas legislature selected many correctional facilities in the state to provide treatment and rehabilitation. According to a Criminal Justice Policy Council (CJPC) report on the performance of rehabilitation programs (2003), as of 2002, the "tier of rehabilitation facilities," as they were called, served up to 9,200 offenders in Texas. In the state of Texas, the Division of Rehabilitation and Reentry manages programs and services for treating the inmate population. The first treatment and therapy programs for substance abuse in Texas became operational in 1992 (Eisenberg, 2003). The in-prison TC and substance abuse programs for probationers are both tracked by the CJPC to ascertain success and failure. In addition to the substance abuse programs, the Texas Department of Criminal Justice (TDCJ) offers treatment counseling to sex offenders and inmates designated with mental impairments. Additionally, the Inner Change Freedom Initiative is a voluntary program for inmates.

TDCJ integrated all treatment delivery programs into a tier system so the department could better address the treatment and therapy needs of offenders in a holistic mode

(Eisenberg, 2003). The TDCJ labeled six rehabilitation treatment plans useful in reducing recidivism and treating offenders in group/individual counseling (Eisenberg, 2003). Four of the six programs use some level of the TC model approach for offenders who will be released into the community. In these four programs, the offenders receive group and individual counseling, substance abuse treatment, anger management, life skills, and vocational and educational instruction. The remaining stages of therapy (sex offender and inner change) programming consists of intensive group and individual counseling, relapse prevention, cognitive skills exercises, community service, and reintegration. With the exception of the Inner Change Freedom Initiative (ICFI), five of the six programs are funded by the State of Texas. The Inner Change Freedom Initiative receives funding from Prison Fellowship Ministries. Each program targets a specific group within the prison system.

The average length of rehabilitation treatment sessions could last from 3 to 30 months before parole or release into the community. Once offenders are released from the programs, they are tracked for two years for recidivism outcomes. The biggest drawbacks to most programs are whether the treatment goals are achieved and are considered adequate for participants in the program.

In Texas TCs, all offenders actively participate in the group process. In the TC, offenders learn cognitive skills in groups; the skills assist the offender to recognize the errant choices made and the offender starts to make positive changes in overcoming the cycle of prison return. According to the Texas Rehabilitation and Reentry Division Web site (2006), the TC treatment group plan in Texas embraces positive ways of thinking, acceptance of oneself through positive criticism, being accountable and responsible for your actions, developing a self-view that is realistic and attainable, setting goals that are achievable, and analyzing performance with the group through counseling. In Texas, most participants enter TC treatment programs as a condition of parole or usually when he/she is within 18 months of release (parole, probation, and max out).

In 1987, the TDCJ recognized mental treatment counseling for offenders classified as mentally challenged. The legislature created a service delivery program, which addresses the specific medical needs of offenders in the prison system (the prison system could be state jails, state prisons, and private jails and prisons). Because of this action, the Texas structure is recognized nationally as a system that tackles all aspects of mental treatment for offenders. The Texas legislature is committed to mental service delivery; the government appropriates a budget each fiscal year to enhance mental health services. The legislature also established the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). Texas merged all mental health counseling for incarcerated offenders in prisons/jails or within the community on parole and still under the jurisdiction of TDCJ. The linkage between the community and institutions in providing mental health offenders' access to medical, psychiatric, and other rehabilitative services significantly benefits offenders.

The TDCJ classifies inmates as mentally deficient through medical diagnosis, often using the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) Axis I. Offenders are also classified if they score 50 or less on the Global Assessment Functioning (GAF) scale, which shows a serious emotional impairment (Biennial report, Texas Council on Offenders with Mental Impairments, 2003). Once classified, offenders have 32 mental health programs offering a range of services. Some services offered include rehabilitation through group therapy, case management, and medication monitoring. Although Texas is a model for other state correctional systems to follow for delivery of

services to the mentally impaired inmate population, it still needs improvement. The state does not follow one particular curriculum or structured delivery service to help offenders diagnosed as mentally deficient.

North Carolina

The North Carolina Department of Correction has a rehabilitation system that balances the treatment counseling needs of the inmate population. One of the newest treatment plans for offenders commenced in 1998. The department uses the cognitive-behavioral intervention (CBI) approach as the foundation for all programs and services. According to research, among rehabilitation programs CBI reduces recidivism through the techniques used, which have an impact on the offender's thinking. CBI is based on the principle that thinking (internal) controls your actions (external) (Price, 2004). Offenders learn new skills and receive training that leads to changes in behavior and action, which could affect the criminals' conduct.

The North Carolina Department of Correction uses CBI effectively in the group counseling process with both substance-abusing and mentally ill offenders. The department followed the research of Ross and Gendreau (1987) on revivification and rehabilitation, which analyzed effective programs that reduced recidivism (as cited in Price, 2004, p. 5) and cited CBI as a valuable technique for offenders. CBI is available to all North Carolina offenders both in correctional facilities and in the community.

The NC DOC approved four CBI curricula for use with the offender population; they include thinking for a change, problem-solving skills in action, reasoning and rehabilitation, and choices and changes (Price, 2004). The majority (85%) of prison facilities use thinking for a change. Problem-solving is the core in the thinking for a change program. Cognitive reform is emphasized in groups and participants learn social skill development and self-change. Problem-solving skills in action (PSSA) instructs offenders in basic social skills for successful problem solving. PSSA is a short-term program usually taught over four weeks to a larger group in interval periods of four days. Each aspect of this program is scripted to allow for greater skill application in groups. The NC DOC uses the reasoning and rehabilitation course developed by Ross, Fabiano, and Diemer-Ewies (1989) in Canada (Price, 2004, p. 6). This program uses a psychoeducational approach with role-playing and demonstration in the groups. The choices and changes curriculum is based on the Wisconsin THINK program. Interactive exercises through role-playing give offenders insight about their thinking and an opportunity to practice social skills with each other.

In addition to offering cognitive behavioral intervention groups to the inmate population, the NC DOC provides substance abuse treatment sessions, which also may use CBI techniques. In 1985, the NC Legislative Research Commission reported that over 67 percent of criminal offenses are connected to alcohol and drug use (North Carolina DOC, Division of Alcoholism & Chemical Dependency Web site, 2006). Thereafter, the department created the Department of Correction Substance Abuse & Chemical Dependency Program. Statewide, there are about 1,500 beds allocated for treating substance abusers in a group setting.

The department has prison-based, community, and residential treatment programs. The department uses the therapeutic community (TC) model approach based on NY DOC's "Stay 'N Out" TC (North Carolina DOC, Division of Alcoholism & Chemical Dependency Web site, 2006). The three programs currently under North Carolina's Department of Correction

authority are the prison-based Drug Alcohol Recovery Treatment (DART), Driving While Impaired DART (DWI DART), and Residential Substance Abuse Treatment (RSAT), in addition to other outpatient community programs with various agencies operated by the NC DOC. Offenders in prison, probation, or parole may be required to attend and complete a TC substance abuse program and most inmates should have no more than 24 months remaining on their conviction sentence.

The DART program became operational in North Carolina in January 1988. Offenders receive counseling in a traditional TC with a structured community hierarchy, one of the foundations of a therapeutic community. Since the majority of program lessons are conducted and acted out in a group (family) style, all offenders participate in the counseling of their peers.

Another counseling modality the North Carolina DOC offers the offender population is mental health group service. The department offers inpatient, outpatient, day treatment, and sex offender treatment programs. According to the Division of Prison Mental Health Web site, the mission of mental health services in NC is to protect, control, reduce, or eliminate conditions, which contribute to the inmate's mental impairment. Under North Carolina statute, the corrections system should provide "preventive, diagnostic, and therapeutic measures for outpatient and hospitalization for all types of patients."

The Department of Correction in North Carolina provides about a 600-bed capacity in numerous facilities to treat mentally ill offenders. In addition, outpatient services are provided to over 30,000 inmates. Offenders are first classified as mentally deficient through a variety of testing instruments (North Carolina DOC, Division of Mental Health Services, 2006). After the testing, inmates classified as mentally handicapped/impaired are tracked through the mental health tracking system. Some offenders are transferred to day treatment centers where they live with like-minded offenders in a dormitory style facility such as Brown Creek Correctional Institution (Brown Creek and Pender Correctional Institutions house offenders in day treatment centers). The offenders receive treatment together. Treatment consists of group counseling, art therapy, social and coping skills, and community reentry. Day treatment programs in NC DOC are effective because offenders interact more with the treatment staff with more freedom set aside for groups, which may help these offenders reintegrate into the general prison population or the community.

The North Carolina Department of Correction uses various techniques for group counseling offenders. Programs target the inmate populace and increase inmate participation awareness by offering reasonable problem-solving skills, which further enhances the outlook for many offenders. Since the 1990s, cognitive and other treatment programs have produced positive outcomes for offenders released from North Carolina prisons, thereby reducing recidivism.

Ohio

The Ohio Department of Rehabilitation and Correction (DRC) have similar counseling models to Texas and North Carolina for inmates. The department cooperates with numerous other state agencies and community partners to deliver counseling services. Ohio took the approach of the Corrections Service of Canada and organized programming into seven domains (Ohio Dept. of Rehabilitation and Correction—IPP, 2006). Ohio classifies inmates

to see which domains fit the offender's programming plan. All interested stakeholders provide substance abuse treatment counseling, and cognitive-behavioral programs for offenders in the prison system, probation, and parole.

One program model the department uses is the "corrective thinking" principle based on the research of Yochelson and Samenow (1976, 1977), called corrective thinking or truthought (Hubbard & Latessa, 2004, p. 3). The corrective thinking approach theorizes why someone commits a crime. The authors surmised that most people recognize dangers in their thinking; criminals tend to exaggerate errors in their thinking and choose to commit crimes.

Rogie Spoon (1999) developed the truthought concept. This concept teaches inmates how to recognize thinking barriers and correct them with positives. Spoon enhanced the original model of Yochelson and Samenow (1976, 1977) with exercises for offenders. Through this training, offenders learn to take responsibility for choices and actions. The core course in Ohio is offered in a group arrangement at five treatment sites. Offenders receive a battery of tests, including sexual abuse history, personality profiles, intelligence testing, and depression scale testing. Although cognitive thinking groups are one form of treatment program in the Ohio Department of Rehabilitation and Correction, researchers from University of Cincinnati, Center for Criminal Justice Research did not find the treatment counseling to be more effective than other group treatment programs (i.e., therapeutic community).

Just like all the other state correctional programs referred to previously, the Ohio DRC provides other forms of group treatment to the inmate population. One such group is the TC. The process of treating substance-abusing offenders begins during the intake process at reception facilities in Ohio. If an offender's criminogenic compulsion is substance abuse, the offender may receive treatment, which helps them abstain from abusing substances.

Ohio operates several alcohol and other drugs (AOD) group treatment programs. Two of the intensive programs are located at North Coast Correctional Treatment Facility, a private facility, and Pickaway Correctional Facility, a state-run therapeutic community facility. Both facilities provide alcohol and other drug treatment for a 90-day period in many forums. The department uses an AOD instrument, PII (Prison Inmate Inventory) method, to screen potential applicants who may benefit from intensive group treatment. Offenders receive primary and secondary programming treatment. Some primary alcohol and other drug treatment consists of group and individual counseling, support/fellowship meetings, AOD education, and biopsychosocial assessment. The Pickaway facility provides these primary services as well as detailed TC programming. After completion of either treatment module, offenders are closely supervised for up to a year and may be required to continue AOD treatment once in the community for a stated time. After completion of each Intensive Program Prisons (IPP) cycle, staff and inmates evaluate the program for effectiveness and both programs conduct monthly quality assurance activities.

The State of Ohio provides the inmate population with many counseling resources to help improve offender's outlook on life once they leave prison. The cognitive behavioral program the state utilizes has worked for most offenders who receive the treatment. However, the state should continue to develop the process with more staff training to ensure all offenders get the best level of counseling available while incarcerated. Ohio should also assess the risk and needs of future offenders through evaluation so that the programs (cognitive behavior and substance abuse) operate more efficiently to improve inmate service delivery.

New Jersey

In New Jersey, the number of treatment services available to the inmate population is substantial. Offenders can receive treatment for mental health, substance abuse, parenting skills, sexual offenses, adaptation/reentry, and so on. Some treatment focuses on cognitive reasoning, which increases offenders' self-esteem and thought processing, while others such as substance abuse focus on promising treatment. New Jersey has dual systems of group counseling delivery for offenders, mental health, and substance abuse groups in the therapeutic community. Sometimes these services can overlap as well.

Mental health offenders in New Jersey now have enhanced counseling services available to them with the creation of University Correctional HealthCare (UCHC). This collaboration between NJ DOC and University of Medicine and Dentistry of New Jersey (UMDNJ) implemented in January 2005 provides mental health care services for inmates in the state's 14 prisons and 26 residential community release (halfway house) facilities. The State of New Jersey was mandated to provide mental group as a requirement under the *CF v. Terhune* settlement in 1999. *CF v. Terhune* was a class action lawsuit originated by inmates to address the lack of support and services accessible for mentally ill prisoners. At the time, mental health services and treatment available to mental inmates was considered the worst in the country.

In accordance with the contract reached between the State of New Jersey and the University of Medicine and Dentistry of New Jersey, the current mission of mental health services in NJ is to provide inmates services that meet the UMDNJ-University Behavioral Healthcare's community standard of excellence (J. Dickert, Ph.D, personal communication, August 11, 2006). The treatment staff at UCHC thoroughly evaluate offenders to determine who needs treatment services. The goal of the mental treatment program is to help offenders minimize symptoms and maximize their functioning, which may improve the chances of completing their convicted incarceration term. To do this, UCHC, the treatment provider, developed the Secure Environment Clinical Treatment (SECT) modality to react to problems unique to a correctional facility. The working standards of SECT comprise 10 basic understandings:

1. Inmates with mental health needs have a right to treatment.
2. Custody officers are allies in the treatment process.
3. Inmates will always be treated respectfully.
4. Effective screening is the beginning of all treatment.
5. Inmates are continually assessed for the appropriate level of mental health care.
6. Inmates are to be treated in the least intensive level of care.
7. Psychoeducation is an important intervention.
8. Clinical supervision is essential.
9. By measuring outcomes, quality of care can be improved.
10. Timely planning for reentry is essential for inmates with mental health needs (J. Dickert, Ph.D, personal communication, August 16, 2006).

In New Jersey, about 3,000 inmates require special mental health services. Another 350 of these offenders need specialized secure housing treatment placement. There are

three inpatient unit settings, stabilization units (SU), residential treatment units (RTU), and transitional care units (TCU). Mental health staff use two group modules for mental health offenders. One program is the neuroscience treatment team partner (NTTP) program, a modular for recovery and wellness through a psychosocial program. Eli Lilly and Company developed NTTP and the Department of Corrections treatment supplier, University Corrections HealthCare employs the service with offenders in mental health. In this component, offenders receive treatment in a structured educational program that encourages a healthy lifestyle. This is transferred over to mentally challenged offenders in prison who receive instruction on understanding their illness and symptoms and learning to apply principles, which will be an asset for the offender once he returns to his neighborhood.

The NJ Department of Corrections also adopted the New Direction curriculum developed by the Hazeldon Foundation. New Direction is a cognitive-behavior therapy (CBT) treatment program that addresses offenders with multiple needs (mental illness and substance abuse history). Offenders are challenged to change their criminal and addictive patterns in a group session. New Direction and NTTP serve a small number of offenders. The department has expanded group counseling treatment for other general population offenders as well. In the first year of the partnership between NJ DOC and UMDNJ-UCHC, group treatment increased from 13.6 to 20.2 percent at the conclusion of 2005. Overall, the levels of mental health groups for offenders in the State of New Jersey have improved. The treatment provider, UMDNJ-UCHC surveyed inmates who receive treatment to determine their level of satisfaction with the services. Out of 3,000 mental offenders, 23 percent (709) responded to the surveys. The survey results were favorable, providing cautious optimism that the groups are working. The strategic two-year plan is progressing as expected.

In addition to providing group counseling services to offenders with mental challenges, the NJ Department of Corrections provides counseling for inmates in the therapeutic community. New Jersey contracts 1,414 beds currently in eight prisons throughout the state. The NJ Department of Corrections receives federal funding under the Residential Substance Abuse Treatment (RSAT) grant for state prisoners. About a third of the available allocated beds are funded through RSAT and other federal funding sources. The NJ Department of Corrections contracts out programming to a substance abuse provider. The selected provider, Gateway Foundation Inc., commenced operation of the inpatient prison TC treatment in October 2002.

The therapeutic community inpatient treatment in New Jersey prisons is one structured for a specific inmate population group. Eligibility for therapeutic community placement is based on several factors; the primary one being the assessment severity index (ASI) instrument (NJ Department of Corrections, Office of Drug Programs fact sheet, 2006). Incoming inmates into the jurisdiction of the state prison system are screened on intake by trained social workers who evaluate the offenders' need for substance abuse treatment. Once identified as needing addiction treatment with an ASI score of five and above, offenders should meet time frame criterion and be able to achieve community corrections minimum custody status for continued treatment beyond the therapeutic community.

The therapeutic communities in the eight New Jersey prisons all have prison-based treatment where the offenders live in the same housing unit and receive program treatment every day. Living on the same housing unit increases the chance for success because all offenders in the family structure are there for the same reason, to receive treatment together. The therapeutic community is planned to address the multitude of socialization and psychological needs of the participating offenders in the community. All program activities and

instruction are preplanned to inspire members of the community. While in the therapeutic community, offenders usually attend daily seminars that focus on anger management, conflict resolution, decision making, and academic teaching. In addition, the program offers group treatment counseling through encounter group sessions. Encounter groups maximize the probability that all offenders will participate in the group sessions and gain insight and perspective, which may help offenders once they are released into the community. The therapeutic communities in New Jersey prisons also provide cognitive skills development. Cognitive skills are utilized to help offenders understand the triggers that cause the addictive behaviors and that may change the thinking process.

The NJ Department of Corrections has taken an enhanced approach to dealing with treatment of the offender population. Diverse group counseling programs are used to gain results that will benefit and possibly avert offenders from returning to prison. It is hoped that the correctional counseling offenders receive will help with the continuum of care component offenders will contact neighborhood providers to continue treatment once released into the community.

Other states in the vicinity of New Jersey provide group counseling services for the inmate population as well. The State of Delaware Department of Correction has an excellent substance abuse program, which is recognized worldwide as being effective in rehabilitating drug offenders. Offenders are tracked through incarceration, work release, and aftercare into the community. The multilevel components of the program are called Key, Crest, and Aftercare. The Key component is a traditional prison therapeutic community setting, while Crest is a work release program. The final module, Aftercare, follows offenders once they leave prison and remain on probation in the community. In all three components, offenders continue to meet at least weekly for group counseling in the continuum of treatment plan (Delaware DOC Substance Abuse Treatment, 2005).

Another neighboring state that provides enhanced group counseling services to a targeted inmate population is the Connecticut Department of Correction (DOC). The comprehensive programs for adult offenders include mental health and substance abuse treatment under the department's health and addiction services office. The Connecticut DOC collaborated with the University of Connecticut Health Center in 1997 to provide managed health care to the offender population. One component is the level of mental health services offenders can receive while incarcerated. All of the state's correctional facilities provide mental health services and four facilities (Garner, Manson Youth, Osborn, and York Correctional Facilities) provide comprehensive care. Offenders can receive individual and group counseling as well as cognitive behavior treatment plans.

In addition to providing mental health services, the Department of Correction in Connecticut has a graduated substance abuse system similar to the tier system of the Texas Department of Criminal Justice. According to the Connecticut Department of Correction, 85 percent of incoming offenders have a substance abuse history. After a formal assessment through the objective classification system, which determines an offender's need for treatment, an offender can be placed in substance-abuse education program in four separate levels. The tier system ranges from six sessions to a 12-month aftercare program. Most of the programs in the tier system focus on substance abuse treatment using the therapeutic community model. Offenders usually receive group counseling, education instruction, relapse prevention, and cognitive development. The tier system was evaluated for effectiveness in 2002 by Brown University's Center for Alcoholism and Addiction Services and the Schneider Institutes for

Health Policy at Brandeis University. The principal investigator, Dr. Daley, and her colleagues found that the tier structure worked favorably. Inmates who attended any tier program of the Department of Correction were less likely to recidivate.

CORRECTIONAL COUNSELING EFFECTIVENESS

According to Lipsey (1992), when he looked at all evaluation studies regardless of their nature, 64 percent of correctional counseling/treatment studies indicated a reduction in recidivism. The average reduction across these studies was 10 percent, an acceptable level according to Van Voorhis, Braswell, and Lester (2004). It has also been indicated that programs that share certain characteristics deemed "appropriate interventions" can produce reductions in antisocial behavior that are correlated with recidivism (Andrews, Bonta, & Hoge, 1990; Lipsey & Wilson, 2001; Van Voorhis et al., 2004).

Specifically, two types of group correctional counseling programs researched and evaluated a great deal are drug/alcohol treatment programs and sex offender treatment programs. The findings from the evaluation studies of these two types of treatment programs have yielded cautiously positive findings. A description of these two types of programs and a brief review of their effectiveness follows.

Sex Offender Group Counseling/Treatment

The group treatment offered to sex offenders at the Adult Diagnostic Treatment Center (ADTC hereafter) in Avenel, New Jersey, is consistent with other North American treatment programs; both cognitive-behavioral treatment and relapse prevention are offered to offenders (Freeman-Longo, Bird, Stevenson, & Fiske, 1994; Zgoba, Sager, & Witt, 2003). Group cognitive-behavioral treatment focuses on reconstructing an offender's cognitive distortions, while relapse prevention programs teach offenders to recognize the patterns that lead up to their eventual offending (Cornwell, Jacobi, and Witt, 1999; Zgoba et al., 2003). This treatment combination is offered to offenders under a hierarchy of five-levels, with each level building on the level before it. Within this five-level context, patients undergo a standard set of psychoeducational modules where they also receive increased responsibilities and therapeutic tasks. Once offenders graduate to the fifth level of involvement, they procure additional responsibilities and make an effort at maintaining the gains they have made in treatment (Zgoba et al., 2003). The levels of the group counseling for sex offenders at the ADTC are as follows (Cornwell et al., 1999; Zgoba et al., 2003):

Level I: Patients receive basic information about sex offending, receive an orientation to treatment, and begin to acquire the skills needed to participate fully in more advanced psychotherapy. Level I treatment is provided in structured, didactic groups.

Level II: Patients begin to use a sex-offender-specific workbook and begin applying knowledge acquired in Level I to their own lives. Treatment focuses primarily on the acknowledgement of responsibility and victim empathy.

Level III: Patients focus on acquiring comprehensive cognitive mastery of information gained at earlier levels. Psychoeducational modules are heavily supplemented

by a core treatment group with less structure. Relapse prevention exercises begin during this level.

Level IV: This level focuses on a more detailed relapse prevention plan and release preparation.

Level V: Patients begin a maintenance program to help them maintain earlier gains. Patients may be placed in a therapeutic community within the walls of the ADTC with additional responsibilities, such as limited self-government.

While the topic of sex offender treatment is often complicated with controversy, the evaluation of many treatment programs and various meta-analyses report positive results to the counseling. Hall's findings (1995) concluded that treatment did result in a small improvement relative to comparison conditions (Hall, 1995; Nicholaichuk, Gordon, Gu, & Wong, 2000). While the effect size for treatment versus comparison groups was small ($r = .12$), it was robust. Additionally, 19 percent of the treated sex offenders committed a sexual reoffense, while 27 percent of the comparison group, the untreated offenders, recommitted a sexual offense (Hall, 1995).

A follow-up meta-analysis conducted by Hanson and Bussiere (1998) contained 61 treatment evaluation studies with an overall sample size of 23,393 sexual offenders. On average, the sexual offense recidivism rate was found to be low with 13.4 percent of the sample committing a sexual offense. Particular subgroups of sexual offenders, as well as offenders who prematurely terminated treatment, recidivated at higher levels. The results of this analysis suggest that there are different predictors for non-sexual and sexual recidivism among offenders (Hanson & Bussiere, 1998).

A subsequent and more recent meta-analysis conducted by Hanson, Gordon, and Harris (2002) examined the effectiveness of psychological treatment for sexual offenders by summarizing 43 studies, resulting in a sample size of 9,454. Similar to the previous meta-analysis, the sexual reoffense rate was lower for the treatment group (12.3%) versus the comparison group (16.8%). Similar patterns were detected for rates of general recidivism, although the rates were predictably higher. Current psychological treatments, namely cognitive behavioral treatment, were associated with reductions in both general and sexual recidivism (Hanson et al., 2002). Overall, as meta-analyses have evolved with an increase in methodological clarity, the picture of sexual offender treatment evaluation studies looks more optimistic.

Substance Abuse Group Counseling

Addiction to drugs and/or alcohol is an issue that affects individuals across all sections of society. As such, it is not surprising that it has such a severe impact on the prison population. Moreover, substance abuse is believed to place offenders at an elevated likelihood of reoffending. It has been estimated that substance abuse problems affect as many as 75 percent of incarcerated offenders (Mumala, 1999; Van Voorhis et al., 2004). NJ Department of Corrections findings indicate similar numbers; recent assessments reveal that nearly 60 percent of incoming inmates have moderate to extreme drug/alcohol addictions and 72 percent have some level of drug/alcohol disorder. In response to the magnitude and pervasiveness of the substance abuse problem, many programs focusing on drug and alcohol abuse have been the subject of increased scrutiny and evaluation. The wide variety of substance abuse interventions that developed over the years has fueled the desire to evaluate correctional

substance abuse programs. Gone are the days of recovery aided only by 12-step programs. Substance abuse interventions have evolved considerably and now follow different approaches and philosophies, including psychodynamic approaches, radical behavior approaches (i.e., classical conditioning, aversion therapies, and covert sensitization), social learning and cognitive-behavioral approaches (therapeutic communities, social skills training, relapse prevention training), drug courts, family therapy approaches, support groups, and pharmacological approaches (Van Voorhis et al., 2004).

Early research on correctional substance abuse programs was not as optimistic as it has now become. Previous studies indicated high relapse rates with little effect from the treatment components. As programs have evolved and treatment techniques have advanced, outcome studies and meta-analyses concerning drug and alcohol counseling for inmates have shown an increased benefit. Meta-analyses now show support for behavioral, social learning, and cognitive-behavioral approaches to treating substance abusers (Miller et al., 1995; Van Voorhis et al., 2004). More specifically, Miller et al. (1995) indicated that programs utilizing behavioral or cognitive-behavioral components were the most effective. Examples of these approaches include social skills training, relapse prevention, motivational enhancement, and community reinforcement (Van Voorhis et al., 2004).

PATHWAY TO IMPROVING CORRECTIONAL COUNSELING

Despite the widespread controversy and competing ideologies over the effectiveness of correctional counseling, according to Schrink and Hamm (1989) and Van Voorhis et al. (2004), the following standards should be set regarding effective group counseling and treatment in a correctional setting. They are as follows:

Correctional Counselors

1. The criteria for gaining employment as a counselor in a correctional setting should include an expectation of hiring individuals with advanced degrees in the relevant fields. This should also extend to include those who have extensive fieldwork in counseling.
2. Requiring that all counselors maintain an understanding that working in a correctional setting is a challenging occupation and that the counselors must be committed to rehabilitating the offenders.
3. Continuously providing correctional counselors with training.
4. It is necessary that correctional counselor job descriptions and mission statements are clear, consistent, specific, and relevant to the job expectations.
5. It is important that caseloads in the correctional setting be reasonably small and include offenders who are amenable to treatment and open to rehabilitation.
6. Group counseling sessions should utilize a multimodal approach that focuses on a more specific direction and small groups. For example, specific group sessions should help rapists, child molesters, offenders with drug problems, and/or anger management.
7. Group counseling programs and counselors should feel supported by the correctional communities and administrators.

Correctional Counseling Programs

1. Program evaluations should be completed in order to accomplish three tasks: (1) identify which programs work and why, (2) monitor strengths and weaknesses of effective programs, and (3) identify opportunities for improvement.
2. It is recommended that treatment (Andrews et al., 1990) be based on behavioral and social learning strategies (i.e., cognitive-behavioral treatment).
3. A collaboration between various disciplines will benefit the correctional counseling program by offering components of health care, education, vocation, recreation, mental health, and substance abuse treatment.
4. Practice of a technique referred to as the "principle of responsivity," whereby characteristics of the offender, therapist, and programs are matched is recommended.
5. Relapse prevention strategies should be offered to assist offenders upon release back into the community after receiving treatment while incarcerated.
6. It is also suggested that life skills and treatment experiences that emphasize personal accountability within the prison institution and in the community be offered.

CONCLUSION

An impressive body of literature provides empirical evidence that rehabilitation works to reduce recidivism (i.e., Andrews et al., 1990; Andrews & Bonta, 2003; Cullen & Applegate, 1997). Despite the known benefits of correctional counseling, offenders who receive treatment while in prison but then reoffend in society get negative press. Treatment of the offender is considered ineffective when the offender commits another crime. A goal for offenders should be learning how to gain insight from the environment they lived in and anticipating new beginnings once they leave the jurisdiction of the criminal justice system. Community corrections play a huge part in helping to rehabilitate offenders. Now that reentry policy and the continuum of care theory is recognized as paramount in keeping offenders from recidivating, community corrections (halfway houses, MAP, ISP, halfway back) are recognized as helping with the treatment modality of offenders. Usually in these programs, offenders continue to get cognitive-behavior intervention, work release, group counseling, and quality of life training. With the wide breadth of resources available to offenders, it is hoped that offenders are able to remain crime free.

According to Van Voorhis et al. (2004), the topic of correctional counseling and treatment is one composed of various mental health professionals working with a population of individuals who have been identified as delinquent or criminal. The services that are provided to the inmates are pervasive across a diversity of settings, including correctional facilities, community-based residential treatment communities, probation and parole settings, departments of human services, and specialized court systems (Van Voorhis et al., 2004). Because of the wide array of treatment and group counseling settings, it is common for different programs to have different goals. The primary question becomes whether counseling should focus on preparing an inmate for a successful return to the community or whether it should concentrate on the inmates' adjustment and existence within the confines of the prison world (Van Voorhis et al., 2004). Over time, it has come to be that many programs simultaneously concentrate on both goals, as it is understood that the manner of

adjustment to the prison community can be correlated with the way a released inmate reintegrates back into society.

Given monetary constraints and inmate-to-therapist ratios, the majority of correctional counseling programs take place in a group-counseling environment. According to Van Voorhis et al., 2004, correctional group counseling sessions are usually held with 5 to 10 inmates in a session that meets once or twice a week for approximately an hour and a half. It is suggested that the appropriate group size should range from 8 to 10 participants because it is small enough for the group members to develop trust for one another and large enough to ensure that participants will not feel pressured or self-conscious. However, there is some question as to whether group counseling is as effective and beneficial to the recipients as individualized counseling. According to research conducted by Lipsey (1992) and Andrews et al. (1990), group counseling was found to be just as effective during meta-analyses studying decreases in recidivism (Van Voorhis et al., 2004; see also Andrews & Bonta, 2003). Given this lack of a difference between group and individual therapy, group therapy has a number of benefits that make it conducive to utilization in a prison setting. These advantages include: (1) the financial aspect, as it is more economical to conduct group therapy, and (2) the motivation garnered by having other inmates present. In other words, sometimes offenders are not motivated to change and they benefit from other inmates' presence, as they consider it a potential facilitator of change (Van Voorhis et al., 2004). Conducting the therapy in a group setting therefore allows for gentle persuasions or unspoken acceptance by the other inmates.

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